



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS BACK INSTITUTE
PO BOX 262409
PLANO TX 75026-2409

Respondent Name

TPCIGA FOR RELIANCE NATIONAL INSURANCE

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-12-0177-01

MFDR Date Received

SEPTEMBER 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Procedure code 22325 was denied as a bundled procedure. According to the NCCI edits, this procedure is not bundled in another procedure billed on this day. Liberty Mutual allowed payment for the Assistant Surgeon.

Procedure code 63710.59 was denied as medical efficacy not established. Dr. Bosita, who is a spinal surgeon is considered to be an expert in his field of medicine. The medical efficacy is established. Again, the Assistant Surgeon was paid for this procedure.

The documentation we submitted was supported by the operative report for both procedures."

Amount in Dispute: \$3,902.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 22325 was denied as bundled/incidental to CPT 63047 and should not be separately billed...CPT 63710 59 was denied as the medical efficacy of Amniotized Amniotic Tissue Barrier has not been established."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2011	CPT Code 22325	\$2199.00	\$1,384.93
	CPT Code 63710-59	\$1703.00	\$1072.93
TOTAL		\$3902.00	\$2,457.86

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - D20-Claim/Service missing service/product information.
 - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.
 - 56-Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
 - X667-The medical efficacy of this procedure has not been established. For Texas jurisdiction claims only, per Texas Labor Code Section 413.031 and 28 Tex. Admin. Code Section 133.308(H), (I), after reconsideration, you may seek review of a denial of medical necessity through a TDI-DWC-appointed Independent Review Organization.

Issues

1. Is the requestor entitled to reimbursement for CPT code 22325?
2. Is the requestor entitled to reimbursement for CPT code 63710-59?

Findings

1. CPT code 22325 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar."

A review of the Operative report indicates that the claimant underwent "a reduction maneuver to try to reduce the L3-4 retrolisthesis."

Furthermore, the requestor submitted a copy of the explanation of benefits from the Assistant Surgeon that support service was paid; therefore, the requestor has supported their position that reimbursement is due.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 68.47.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75093, which is located in Collin County.

The Medicare participating amount for code 22325 in Collin County is \$1,374.47.

CPT code 22325 is subject to multiple procedure rule discounting.

Using the above formula, the MAR is \$1,384.93.

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The respondent paid \$0.00. As a result, \$1,384.93 is recommended for reimbursement.

2. CPT code 63710 is defined as "Dural graft, spinal."

A review of the Operative report indicates that "I placed AmnioShield tissue membrane graft over the exposed thecal sac."

Furthermore, the requestor submitted a copy of the explanation of benefits from the Assistant Surgeon that support service was paid.

Because payment was issued for the Assistant Surgeon, the respondent's denial based upon therefore, the requestor has supported their position that reimbursement is due.

The Medicare participating amount for code 63710 in Collin County is \$1064.83.

CPT code 63710 is subject to multiple procedure rule discounting.

Using the above formula, the MAR is \$1,072.93.

The respondent paid \$0.00. As a result, \$1,072.93 is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,457.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,457.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

7/8/2013
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.